# SENIOR & LONG TERM CARE DIVISION
# COMMUNITY SERVICES BUREAU

| HOME AND COMMUNITY BASED WAIVER Policy Manual | Section: ELIGIBILITY FOR SERVICES |
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| | Subject: Slot Categories |
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**DEFINITION** Slot categories are mechanisms for tracking Home and Community Based Services (HCBS) Program costs.

**CATEGORIES OF SLOTS**

Slots fall into three main categories:

1. BASIC SLOTS: These slots include elderly (over the age of 65) and physically disabled (under the age 65). Individuals under the age of 65 must have been declared disabled by the Social Security Administration. Case Management Team (CMT) is allotted a specific number of basic slots. Service plan costs for these slots may not exceed the established upper limit without prior authorization.

2. ADULT RESIDENTIALSLOTS: Adult Residential is an HCBS service under Residential Habilitation. (See HCBS 728). Individuals in an adult residential slot must be age 18 or older; this service is available in assisted living facilities and adult foster homes. CMTs are allocated a fixed number of adult residential slots for individuals requiring this service. Service plan costs for these slots may not exceed the established upper limit without prior authorization.

3. CARE CATEGORY 3 SLOTS (CC3): For procedure requirements on the temporary conversion of slots refer to HCBS 805. CC3 slots include the following sub-categories:

    a) Supported Living —Funds for this service are limited in number and distributed by the Department based on need and availability of funding. Refer to HCBS 736 for a description of Supported Living services.

    b) Heavy Care/Ventilator Dependent —Funds for this service are limited and distributed by the Department based on need and availability of funding.

c) Specialized Residential Habilitation Slots – These are limited in number and distributed by the Department. See HCBS 728 for more information.

d) Group Home —. See HCBS 728.

e) Bridges/Headway---TBI services provided under the HCBS service Post-Acute Rehabilitation. This service is a residential or a non-residential program for persons with a traumatic brain injury, or other severe disability that would benefit from extensive rehabilitation. See HCBS 725 for more information and specific referral process.

**PROGRAM ELIGIBILITY**

The Department will determine eligibility for enrollment of Care Category 3 due to the high cost of services and the limited number of slots. The Community Services Bureau will allocate these slots to Case Management Teams via the Regional Program Officer upon request when a consumer has been determined to be eligible for CC3. CC3 slots must be returned to the Community Services Bureau when the consumer is discharged from the slot. Some slots may be allocated to specialized adult residential care facilities and these slots remain with the facility.

**REFERRAL PROCEDURES FOR BASIC AND ADULT RESIDENTIAL CONSUMERS**

Responsibility and Action:

1. Mountain Pacific Quality Health:
   a) Screens individual to determine level of care.
   b) Refers individual to Case Management Team if individual meets level of care.

2. Case Management Team (CMT):

   a) Must initiate contact within five working days of receipt of referral. Onsite visits must be made within 60 days of the referral. If extenuating circumstances prevent this visit from occurring within 60 days, the CMT must document the reasons and complete the visit as close to this date as possible. Refer to HCBS 405 Mode of Response for clarification.

**REFFERAL PROCEDURES**

**FOR CC3 CONSUMERS** Responsibility and Action:

1. Mountain Pacific Quality Health:
   a) Screens individual to determine level of care.
   b) Refers individual to Case Management Team if individual meets level of care.

2. Case Management Team (CMT):
   a) Assesses the individual to determine the type of service required.
   b) Completes Request for Prior Authorization for CC3 individual using DPHHS-SLTC-148. (Refer to Appendix 899-21.) Exception: See HCBS 725 for referral procedure for Bridges/Headways.

   c) Submits to the Regional Program Officer: Initial Plan of Care, Cost Sheet, and Prior Authorization for CC3.

3. Regional Program Officer (RPO):
   a) Reviews initial Plan of Care documents.
   b) Signs initial Request for Prior Authorization for CC3.
   c) Submits referral package containing all documents to the Community Services Bureau for initial CC3 slots.

4. Community Services Bureau:
   a) Approves or denies request.
   b) Notifies RPO by completing the bottom section of the Request for Prior Authorization for CC3.

5. Regional Program Officer:
   a) If approved, forwards Request for Prior Authorization to CMT.
   b) If denied, the RPO notifies applicant/consumer via the Letter of Notification, DPHHS-SLTC-144. (Refer to Appendix 899-18.)